HumanaPPO Summary of Benefits

City Of Brazil - Core Plan

INDIANA	Standard Copayment 80/50 Plan	Plan pays for services from ***PARTICIPATING*** providers	Plan pays for services from ***NONPARTICIPATING*** providers
Preventive Care (1)	• Routine immunizations *(to age 18)* • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray	**100%**	**50%** after deductible
	• Routine exams *(18 years and above)* • Routine child exams *(to age 18)*	**100%** after office visit copayment	**50%** after deductible
	• Preventive endoscopy *(includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)*	**80%** after deductible	**50%** after deductible
Physician Services (1)	• Office visits • Diagnostic tests, lab and X-rays *(copayment does not apply)* • Allergy testing *(copayment does not apply)*	**100%** after $20 primary care physician/ $35 specialist	**50%** after deductible
	• Inpatient services • Outpatient services *(includes surgery)* • Office surgery	**80%** after deductible	**50%** after deductible
	• Allergy injections	**100%** after $5 copayment per visit	**50%** after deductible
	• Emergency room physician visits	**100%** after deductible	**100%** after participating deductible (2)
Facility Services	• Inpatient hospital care • Outpatient surgery • Outpatient nonsurgical care *(does not include advanced imaging or emergency care)*	**80%** after deductible	**50%** after deductible
	• Outpatient advanced imaging *(hospital only) (PET, MRI, MRA, CAT, SPECT)*	**100%** after $150 copayment, and after deductible	**50%** after deductible
	• Outpatient advanced imaging *(when performed at a freestanding facility or clinic) (PET, MRI, CAT, SPECT)*	**100%** after $100 copayment, and after deductible	**50%** after deductible
	• Hospital emergency services *(facility charge only) (emergency room copayment waived if admitted)*	**100%** after $150 copayment, and after deductible	**100%** after $150 copayment, and after participating deductible (2)
Prescription Drugs *(includes oral contraceptives)*	• See attached pharmacy benefit information, if applicable		
Other Medical Services	• Skilled nursing facility *(up to 60 days per calendar year)* (3), (7) • Hospice *(inpatient and outpatient)* (3) • Home health care *(up to 100 visits per calendar year)* (3), (7) • Physical, occupational, cognitive, speech and hearing therapy *(combined limit for all therapy services up to 45 visits per calendar year) (7)*	**80%** after deductible	**50%** after deductible
	• Urgent care facility • Chiropractic services *(up to 20 visits per calendar year)* (7)	**100%** after specialist copayment per visit	**50%** after deductible
	• Durable medical equipment *(limited to $5,000 of covered services per calendar year)* (3)	**50%** after deductible	**50%** after participating deductible
	• Ambulance	**80%** after deductible	**80%** after participating deductible (2)
	• Transplant services (3), (4)	Same as any other illness *(when services are received from a Humana Transplant Network provider)*	Same as any other illness *(not subject to a separate out-of-pocket maximum)*

HumanaPPO combines the cost-saving incentives of a modern health plan with freedom of choice. When you see participating providers, you receive the highest level of benefits available under your plan. At the same time, you retain the flexibility to see any physician.

Limitations and Exclusions

This is a partial list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Certificate of Insurance for this complete listing. The Certificate of Insurance is the document upon which benefit payment will be determined.

Pre-existing condition limitation
Health insurance benefits are excluded for a pre-existing condition for 9 consecutive months following your enrollment date, 15 months for late applicants. The exclusion does not apply to:
- Pregnancy;
- Genetic information in the absence of a diagnosis of the condition related to the information; or
- Newborn children or children adopted before the age of 18 if they are covered under the policy within 31 days of the date of birth or date of placement for adoption.

The pre-existing condition limitation shall not be applied to you if you were continuously covered for an aggregate period of nine months under creditable coverage, if your coverage was continuous to a date not more than 63 days prior to the enrollment date under this policy.

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

1. Treatments, services, supplies or surgeries that are not medically necessary, except for the specified routine preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of the Certificate.
2. A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.
3. A sickness or bodily injury, which is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
4. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
5. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
6. Prescription drugs, including vitamins, birth control pills, and self-administered injectable drugs unless administered to you:
   a. while an inpatient in a hospital, or skilled nursing facility, or health care treatment facility;
   b. by a health care practitioner during an office visit; or
   c. by a home health care agency as part of a covered home health care plan when approved by us.
7. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
8. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.
9. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
   a. resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
   b. resulting from congenital disease or anomaly of a covered dependent child, which resulted in a functional impairment.

   A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.
10. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the Certificate.
11. Custodial care and maintenance care.
12. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by or exacerbated by obesity, including but not limited to surgical procedures.
13. Alternative medicine.
14. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an accident or following cataract surgery as stated in the Certificate).
15. Expenses for treatment of complications of non-covered procedures or services.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing the procedure, treatment or supply; however, the procedure, treatment or supply will not be a covered expense.

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HumanaPPO Rx4 Prescription Drug Coverage

Level One - $10, Level Two - $35, Level Three - $55, Level Four - 25%

How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** highest copayment for high-technology drugs (certain brand-name drugs, biotechnology drugs and self-administered injectable medications).

- If you request a brand-name drug when a generic equivalent is available, you pay the applicable Level One or Level Two generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing "Dispense as Written" on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a "Dispense as Written" prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. In the event drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your physician to determine appropriateness or clinical effectiveness with respect to you or any specific illness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana's Website, **www.humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana's Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

For a complete listing of participating pharmacies, please refer to our Website or your participating provider directory.

Coverage at participating pharmacies

When you present your membership card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

Drugs assigned to:	Copayment per prescription or refill
Level One:	$10
Level Two:	$35
Level Three:	$55
Level Four:	25%* of the total required payment to the dispensing pharmacy per prescription or refill.

* The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to $2,500 per calendar year, per member.

- If the dispensing pharmacy's charge is less than the corresponding copayment, you will only be responsible for the lower amount.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

There are no claim forms to file if you use a participating pharmacy and present your membership card with each prescription.

Limitations and exclusions *(cont'd)*

- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications.
- Treatment for onychomycosis (nail fungus).
- Any portion of a prescription or refill that exceeds a 30-day supply (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy). {AR NC TN – Any portion of a prescription or refill that exceeds a 30-day supply (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy or received from a retail pharmacy that has agreed with us to dispense such dosages.)}
- Legend drugs which are not recommended and not deemed necessary by a health care practitioner.
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75 percent of the previous prescription, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, in which case you have used, or should have used 66 percent of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner.)

This is only a partial list of limitations and exclusions. Please refer to the Certificate of Coverage for complete details regarding prescription drug coverage.

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